STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003312	A. BUILDING _____ B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HEART HOSPITAL THE	8075 N SHADELAND AVE INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State complaint. Complaint #: IN00090793 Substantiated; no deficiencies related to the allegations are cited Date of Survey: 08/29/12 Facility #: 003312 Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor The Indiana Heart Hospital is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 09/18/12	S 000		